MINNESOTA
BOARD OF MEDICAL PRACTICE

335 Randolph Avenue, Suite 140
St. Paul, MN 55102
612.617.2130 (phone) | 612.617.2166 (fax)
medical.board@state.mn.us | mn.gov/boards/medical-practice

RESPIRATORY THERAPIST
Application Instructions and Requirements

Please thoroughly review these materials before submitting your application. Any processing fees incurred are your responsibility. The Board reserves the right to reject any outdated applications submitted; therefore, it is recommended that you complete the application in a timely manner. Incomplete applicant files will be destroyed after six months of inactivity.

Methods of Licensure

The statute establishes eligibility for licensure by general or reciprocity, and applicants must select one on the application. All applicants must submit a completed application and appropriate fees online at MN Health Board or by paper to the Medical Board.

General Licensure Requirements

- Verification of successful completion of an approved accredited education program.
- Verification of successful completion of the NBRC or CSRT exam within 5 years prior to application for licensure.

Licensure by Reciprocity Requirements

- Verification of current and unrestricted license from another state requiring an approved education program and NBRC or CSRT certification
- Verification of valid and current NBRC or CSRT certification
- Verification of employment as a respiratory therapist for at least 8 weeks of the previous 5 years

The following requirements must be sent directly to the Minnesota Board from the facility/person completing the form:

- **Verification of NBRC or CSRT certification:** NBRC offers a credential verification service on their website at https://www.nbrc.org/ and CSRT at https://www.csrt.com/.
- **Verification of Respiratory Therapist Education** (General Licensure Only): Verification of Respiratory Therapist Education Form is for certification of respiratory therapy education for general licensure applicants and must be completed and emailed or mailed by the facility directly to the Medical Board.
- **Direct verification of active/expired Licensure/Registration/Certification**: The Verification of Licensure/Registration/Certification Form or the verification of licensure letter can be sent from the state to the Medical Board by email or mail. Verification letters can also be requested through VeriDoc Inc. to the Medical Board. Go to https://www.veridoc.org/ to have a verification letter sent from another participating state board to the Medical Board. If the state does not do verifications, please forward the email response from state stating they do not do verifications or email the link to the state website showing the verbiage the state does not do verifications to the Medical Board and attach the pdf verification from the state website.
  The Board must receive a separate verification form completed by each state board where you have ever held a healthcare professional license/registration/certification.

In addition to the documentation requirements set forth under the general or reciprocity licensure requirements, all of the following requirements must be met:

- Non-refundable $222.00 fee paid online by credit/debit card or submit paper application with check, money order, or cashier's check payable to the **Minnesota Board of Medical Practice.** Cash will not be accepted. Any cash received will be returned, and processing of your application may be delayed.
- The name on the application and the name on the NBRC or CSRT certificate must be the same. If there has been a name change, submit a copy of the supporting documentation, e.g., marriage license.
- Affidavit of Applicant Form A recent, full-face, 2" X 2" color photograph must be affixed as indicated on the form and notarized as a true likeness. Please ensure to fill in and sign all required areas of the form.
- Work History Form
- Copy of respiratory therapy education diploma (General Licensure Only)
- Respiratory Therapist Verification of Employment Form (Reciprocity Only)
- Copy of driver's license or other government issued photo ID.
- Criminal Background Check: applicant will receive emailed instructions once the application is processed. **Use ORI number for Board of Medical Practice: MN920158Z on CBC forms.**
- Any other information requested by the Board.

Application Fees

Please be aware that all fees are non-refundable. Fees submitted will not be refunded if it is determined that you are not eligible for licensure.

Applicants are required to submit written notification to the Board within 30 days of any name or address change. The law takes precedence over any conflicts between these instructions and the law.

APPLICATION FOR RESPIRATORY THERAPIST LICENSE

MINNESOTA BOARD OF MEDICAL PRACTICE
335 Randolph Avenue, Suite 140
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612-617-2130 or mn.gov/boards/medical-practice

Hearing Impaired-Minnesota Relay Service
Metro Area 651-297-5353
Outside Metro Area 1-800-627-3529

Date of Application:

Month	Day	Year

For Board Use Only

Application #: _____

Check/Receipt #: _____

Amt Paid: _____

License #: _____

ACCOUNT CODE	AMOUNT
635024 reg	
635025 app	
635064 cbc	

Instructions to Applicant

1. Enter all dates as Month/Day/Year.
2. Please type or print and answer all questions completely and accurately. Failure to answer all questions completely and accurately, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.
3. Have attached forms completed and submitted to our office, where applicable.
4. Read the attached rules regarding Respiratory Therapist licensure.
5. See the attached License Instructions for information regarding fees to be submitted with your application.
6. The name you enter must exactly match the name on your Respiratory Therapist certificate or documentation of formal name change must be submitted.
7. The application fee is not refundable.
8. Incomplete applications will be destroyed after six months inactivity.

YOUR CURRENT NAME AND ADDRESS: Minn. Stat. 13.41, Subd. 2 requires designated contact information to be PUBLIC and it will be placed on license and Board website. You may change this information online, upon licensure, by following instruction letter issued at that time.

Full Legal Name: Last	First	Middle

Street Address:

City:	State or Province:	Zip Code:	Country:

Home Phone:	Email:	Gender	Other Names:

Social Security or Alien Registration Number:

Record of Birth

Birthdate (Mo/Day/Year) / /	City of Birth:	State of Birth:	Country of Birth:

NBRC Information

Date of Certification (Mo/Day/Year) / /	Certification/ Registration Number:	Expiration Date (Mo/Day/Year) / /

Basis for Application (Check One)

☐ General License ☐ Reciprocity

Preliminary Education

Name of High School:	City:	State or Province:	Zip Code	From Date:	To Date:
Name of College:	City:	State or Province:	Zip Code:	From Date:	To Date:
Type of Degree:	Name of Issuing School:	City:	State or Province:	Date Degree Received:	

Respiratory Care Education

Institution	City	State	Zip Code	From Date Month/Day/Year	To Date Month/Day/Year	Degree/ Certificate

Other Education and Training

Institution	City	State	Zip Code	From Date Month/Day/Year	To Date Month/Day/Year	Degree/ Certificate

STATE/PROVINCES/COUNTRIES IN WHICH YOU ARE OR HAVE BEEN LICENSED OR REGISTERED
List all health professional licenses

State/Province/Country	Health Profession	License/Registration Number	Date Issued Month/Day/Year	Exam

Drivers License

State:	License Number:

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Work History

Per MN Statute, 147C.15 subdivision 1 (v), the Board requires applicants to provide their work history for the five years preceding their application, including the average number of hours worked per week. List your five-year work history below in chronological order. If employed through a staffing agency as a traveler, list each work assignment (such as hospital), rather than the agency. Use additional sheets as needed.

If enrolled in an educational program or unemployed, indicate on form, including dates.

From (mo/yr): ____________ Name of employer: ______________________________
City: ______________ State: ______ Country: ______________
To (mo/yr): ____________ Position/job title: ______________________________
Average number of hours worked per week: ______________________________

From (mo/yr): ____________ Name of employer: ______________________________
City: ______________ State: ______ Country: ______________
To (mo/yr): ____________ Position/job title: ______________________________
Average number of hours worked per week: ______________________________

From (mo/yr): ____________ Name of employer: ______________________________
City: ______________ State: ______ Country: ______________
To (mo/yr): ____________ Position/job title: ______________________________
Average number of hours worked per week: ______________________________

From (mo/yr): ____________ Name of employer: ______________________________
City: ______________ State: ______ Country: ______________
To (mo/yr): ____________ Position/job title: ______________________________
Average number of hours worked per week: ______________________________

From (mo/yr): ____________ Name of employer: ______________________________
City: ______________ State: ______ Country: ______________
To (mo/yr): ____________ Position/job title: ______________________________
Average number of hours worked per week: ______________________________

Applicant Name______________________ Last 4 digits of SSN ________ Date____________ Page __ of __

Attestation questions: Please answer all questions by selecting Yes or No and provide an explanation when requested. If responses to questions change during the time your application is pending, you must make the board aware of the new information. If additional space is necessary, please attach a separate sheet.

Yes No 1. Do you currently have any condition that is not being appropriately treated which is likely to impair or adversely affect your ability to practice respiratory therapy with reasonable skill and safety in a competent, ethical, and professional manner? If yes, please describe.

_____

_____

Yes No 2. Does your use of alcohol or chemical substance(s), including prescription medications, in any way impair or limit your ability to practice respiratory therapy with reasonable skill and safety? If yes, please describe.

_____

_____

Yes No 3. Are you engaged in the use of illegal controlled substances (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained pursuant to a valid prescription of a licensed health care provider)? If yes, please describe.

_____

_____

Yes No 4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders? If yes, please describe.

_____

_____

Yes No 5. Have you ever been the subject of an investigation by any federal, state, or local agency having jurisdiction over controlled substances? If yes, please describe.

_____

_____

Yes No 6. Have you ever been denied a license, or the privilege of taking an examination before any respiratory therapy examining board, or has a conditioned license been issued to you by any state board or licensing authority? If yes, please describe.

_____

_____

Yes No 7. Has your license to practice respiratory therapy in any state or country been voluntarily or involuntarily (i.e. by state board order or any other form of disciplinary action) revoked, suspended, restricted, or conditioned by a state board or other licensing authority? If yes, please describe.

_____

_____

Yes No 8. Have you ever been notified of an investigation by a state board, respiratory therapy society, or health facility of any complaints against you relative to the practice of respiratory therapy, or have you been reprimanded or censured by any respiratory therapy or licensing board? If yes, please describe.

_____

_____

Yes No 9. In the five-year period of active practice preceding the date of filing your application, have you been a defendant in any malpractice lawsuits, had any malpractice settlements, or have any pending? If yes, give a detailed clinical explanation of each case and provide documentation of the outcome (insurance papers or court documents).

Yes No 10. Have you ever been denied, restricted, or revoked staff affiliations with a hospital, nursing home, clinic, or other healthcare facility? If yes, please describe.

_____

_____

Yes No 11. Have there ever been any criminal charges filed against you, whether the charges were misdemeanor, gross misdemeanor, or felony? This includes any offenses which have been expunged or otherwise removed from your record by executive pardon. If yes, submit a personal statement regarding the date of conduct, state and local jurisdiction in which the charges were filed, date of closure, what role you played, and the outcome. If the charge involved the use of alcohol or other chemicals, include in your personal statement whether a chemical dependency evaluation was done (and if so, submit results) and a description of your current drinking or other substance use habits.

RIGHTS OF SUBJECTS OF DATA

This information is requested by the Minnesota Board of Medical Practice. The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. The information is classified as private while your application is pending or if your application is denied, and as public if your license is granted. You are required to submit this information. Your application will not be processed without it and the form will be returned to you for completion. This information may be used as the basis for further investigation by the Board into your qualifications. Under some circumstances, the information could become available to other agencies or persons authorized by law to have access. Attach a separate page for detailed explanations, when appropriate. Failure to answer all questions completely and accurately, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.

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AFFIDAVIT OF APPLICANT:

State of: _____ County of: _____

I, _____, swear that I am the person described and identified in this application and that I have not engaged in any acts prohibited by Minnesota statutes and rules.

I hereby authorize all educational institutions, hospitals, medical institutions or organizations, clinics, my references, personal physicians, employers (past and present), business and professional associates (past and present), all Governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Board any information, files, or records including (but not limited to) transcripts, medical records, personnel files, and any information, favorable or otherwise, the Board may require for its evaluation of my professional, ethical, and physical qualifications for licensure in Minnesota.

I hereby release, discharge, and exonerate the Board, its agents, and representatives, and any person furnishing information to the Board from any and all liability of every nature and kind arising out of the furnishing of oral information or of documents, records, or other information to the Board.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice in Minnesota. I understand that I am required to update my application with pertinent information to cover the time period between date of application and date approved by the Board.

Sworn to before me this _____ day of _____ , _____ . _____
Signature of Applicant

Signature of Notary Public _____

My Commission Expires: _____

Certification of Identification
(Certification of Notary Public is required.)

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. Sworn to before me by the applicant

on this _____ day of _____ , _____.

Signature of Notary Public _____

Expiration Date _____ / _____ / _____

Paste a recent photo, front-view passport-type photo in this square

_____ Notary Seal _____

_____
Signature of Applicant

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ADDENDUM TO APPLICATION

1. BUSINESS ADDRESS

Effective August 1, 2012, Minn. Stat. §214.073 requires licensees to provide their primary business address at the time of initial application and all subsequent renewals. Your primary business address is public and you are required to submit it for application purposes. Your license will not be issued without it unless you check the box below certifying that you are not currently in the workforce related to your practice.

Facility name _____

Street Address_____

City _____ State_____ Zip_____

☐ I certify that I am not currently in workforce related to my practice, and I don't have a business address related to my practice.

2. MILITARY STATUS

Are you or your spouse returning from active military duty (discharged less than 6 months ago) or still in active military duty?

☐ No ☐ Yes. If discharged, please provide discharge date: _____

3. CRIMINAL CONVICTIONS

Effective July 1, 2013, Minn. Stat. §214.072 requires the Board to collect and post on its website the names and business address of each regulated individual who has be conviction of a felony or gross misdemeanor occurring on or after July 1, 2013 in any state or jurisdiction. This information shall be posted for new licensees issued a license on or after July 1, 2013 and for current licensees upon license renewal occurring on or after July 1, 2013. This information is public and you are required to submit it for application purposes. You must notify the Board if a previously reported conviction has been expunged and provide written documentation of expungement.

If you have more than one item to report please attach additional sheets.

Conviction Date (mm/dd/yyyy): _____

Conviction Type (Check one): ☐ Felony ☐ Gross misdemeanor

Crime Description: _____

City: _____ State: _____ County: _____ Country: _____

Sentence:_____

_____

☐ I certify that I have had no convictions on or after July, 1, 2013

Applicant Name_____ Last 4 digits of SSN_____ Date_____

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RESPIRATORY THERAPIST
Verification of Respiratory Therapy Education

This form is for certification of respiratory therapy education for general licensure applicants and must be completed and **emailed or mailed by the facility directly to the Minnesota Board of Medical Practice**. Any processing fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name: _____ SS#:_____

Signature:_____ Date:_____

Date of Degree(mo/day/yr)_____ Degree Received_____

* *

The School completes the following information:

It is hereby certified that: _____
(Name of Applicant)

Matriculated in: _____
(Name of School)

Program located at: _____
(City/State of School)

And received a diploma conferring: _____ On:_____
(Degree) (Mo/Day/Year

Program accredited by: (check one)
___ Commission on Accreditation of Allied Health Education Programs (CAAHEP)
___ Committee on Accreditation for Respiratory Care (CoARC)
___ Commission on Allied Health Education and Accreditation (CAHEA),
___ Council on Accreditation for Respiratory Therapy Education (Canadian) (CoARTE)
___ Other (explain)_____

Any disciplinary action? Yes*_____ No_____

Any derogatory information on file? Yes*_____ No_____

President, Secretary Dean, Registrar

School

Seal**

Print Name:_____

Signature:_____

Title: _____

Date: _____

Phone: _____ Fax_____

*Please attach letter of explanation.
**If there is no seal, attach letter of explanation on letterhead.

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RESPIRATORY THERAPIST
Verification of Licensure/Registration/Certification

This form is for verification of all respiratory therapist and other health care professional licenses or registrations from every board issuing any type of license, registration or certifications including training and temporary permit even if license is not current. **Each Board completing the form must email or mail directly to the Minnesota Board of Medical Practice**. Any fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Your Name:_____SS#: _____

Signature: _____ Date: _____

* *

The State Board completes the following information:

It is hereby certified that: _____
(Name of Applicant)

Date of birth: _____
(Month / Day / Year)

Was issued license/registration number: _____

By: _____ On:_____
(State) (Month / Day / Year)

Expiration date is:_____
(Month / Day / Year)

Issued on the basis of: _____

Disciplinary action ever initiated, pending, or invoked? Yes*_____ No _____

Ever voluntarily relinquished license? Yes*_____ No _____

State Seal**

Print name: _____

Signature: _____

Title: _____

Date: _____

*If yes, please attach letter of explanation.
**If there is no seal, attach letter of explanation on letterhead.

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RESPIRATORY THERAPIST
Verification of Employment

If you are applying for licensure by reciprocity, you must have worked at least 8 weeks of the previous 5 years as a respiratory therapist. To verify your work experience, **this form must be completed by your employer and emailed or mailed directly to the Minnesota Board of Medical Practice**. Any fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Your Name _____SS#_____

Signature _____ Date _____

* *

Employer completes the following information

It is hereby certified that _____
(Name of Applicant)

Was/is employed by _____
(Name & Location of Employer)

From_____ To _____

Please check one: Full time _____ Part time _____

Number of hours per week:_____

Applicant has worked at least eight weeks of the previous five years as a respiratory therapist:

Yes_____ No _____

I certify that all information provided is accurate and correct.

Name of Administrator:_____
Print Name

Signature _____ Date_____

Title _____ Phone number _____